Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D. C. 20554

In the Matter of:

	)
Notice of Proposed Rulemaking (NPRM)	)WC Docket No. 02-60
Regarding the Universal Service Support Mechanism for Rural Healthcare.	)

Comments of the Office of Telemedicine of the University of Virginia Health System

Karen S. Rheuban, MD
Eugene Sullivan, MS

Office of Telemedicine
University of Virginia
Box 800707
Charlottesville, Virginia 22908
434-924-5470

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The Office of Telemedicine of the University of Virginia Health System (U. Va.) submits the following comments in response to the Commission's Notice of Proposed Rulemaking (NPRM) in the above captioned proceeding.

The University of Virginia is a state-supported University; our academic health center is a quaternary care 600 bed healthcare facility which includes a medical school, nursing school and facilities for graduate medical education. We serve as the hub of a 40 site telemedicine network primarily serving citizens in rural regions of the Commonwealth of Virginia. Through this network we provide clinical consultative services, health professional education and patient education with the goal of enhancing access to quality care not locally available in rural communities. To date we have helped to facilitate more than 4500 clinical encounters between remotely located patients (many of whom reside in rural, medically underserved Appalachian communities) and our specialist physicians. We have broadcast thousands of hours of educational programs.

This network is facilitated by broadband connectivity delivered via a host of technologies, to include ISDN (H.320 video protocols), DSL and T1 connectivity (H.323 video protocols). We have chosen to procure equipment that is both scaleable and open architecture so as to give us flexibility as to the mode of transport and connectivity within our own and to other networks.

Many of the rural sites in our telemedicine program have been funded through federal, state and foundation grants (federal: NTIA, USDA, HRSA) and local investments by community partners. Sustainability of these programs is dependent upon both a) our ability secure reimbursement from various payers for the delivery of healthcare services, and more critically, b) a reduction in the high cost of ongoing connectivity.

Introduction and Summary

The passage of the Telecommunications Act of 1996 has resulted in enhanced competition and greater numbers of providers of broadband connectivity in the major urban population centers in our nation. However, rural communities have yet to reap the full benefits of competition and choice as intended by the Congress.[1]

Through the Universal Service support mechanism, the Congress intended to provide discounted telecommunications services to high cost areas, low income citizens, schools and libraries and to healthcare providers in rural communities. In this latter portion of the statute, the intent of the Congress was to reduce financially burdensome disparities inherent in the provision of such telecommunications services to rural healthcare providers who wish to enhance access to locally unavailable healthcare and health related educational services for their patients using broadband connectivity. Rural Americans face the immense physical and financial burdens of travel for access to healthcare services. In many cases, such care is obtained "too little, too late," and the implications for this lack of timely access to quality healthcare cannot be overstated.

Unfortunately, in the first few years of the Rural Healthcare Support program, only 1.4% of the funds authorized by the Congress and the FCC have been distributed. Indeed the vision of enhanced connectivity in the service of improving access to healthcare and health related education programs in rural America has been jeopardized by disappointingly narrowly interpreted rules and administrative burdens that tax even the most sophisticated

[1] FCC 02- 33 In the Matter of Inquiry Concerning the Deployment of Advanced Telecommunications Capability to All Americans in a Reasonable And Timely Fashion, and Possible Steps To Accelerate Such Deployment Pursuant to Section 706 of the Telecommunications Act of 1996.

healthcare providers. This is in sharp distinction to the very successful Schools and Libraries program, in which virtually all the authorized funds have been dispersed annually.

We strongly believe that the FCC has, within its jurisdiction, the ability to more broadly interpret the intent of the Congress such that this still nascent field of telehealth may one day flourish, attributable in part to enhanced connectivity for purposes of providing access to quality healthcare for all our rural citizens.

We applaud the Commission's desire to modify the Rural Healthcare Support Mechanism. In the following pages, we hope to offer comments that will provide useful alternatives or enhancements of the current rules.

A. Eligible healthcare providers should be expanded to include a broader number of providers.[2]

The Telecommunications Act of 1996 identifies healthcare providers eligible to receive discounts under the auspices of the Rural Healthcare Support mechanism by identifying "public and non-profit healthcare providers" as:

1. post secondary educational institutions offering healthcare instruction, teaching hospitals medical schools;
2. community health centers or health centers providing healthcare to migrants;
3. local health departments or agencies;
4. community mental health centers;
5. not-for-profit hospitals;
6. rural health clinics; and
7. consortia of health care providers consisting of one or more entities described in clauses 1-6.

The FCC, in the Universal Service Order, previously refused to expand the definition of eligible healthcare providers.[3] However, we believe that a combination of factors, including lower than anticipated utilization of the Rural Healthcare support mechanism, and our nation's critical need to foster enhanced connectivity among our health providers in the service of homeland security suggest that the definition of eligible healthcare providers be expanded.

We believe that any not-for-profit healthcare facility that provides DIRECT medical services to rural citizens should be considered eligible for discounted telecommunications services under the umbrella of the Rural Healthcare Corporation. These facilities should be expanded to also include such entities as nursing homes, dental clinics, school health clinics, and emergency medical service facilities, but not

[2] NPRM Rural Healthcare Support Mechanism FCC 02-122; WC Docket No 02-60, May 15, 2002 paragraph 6.

[3] Universal service order, 62 FR32862, June 17, 1997.

facilities whose mission does not include the provision of direct patient care. As an example, the need for connecting nursing homes with healthcare providers is great. There is likely no other patient population which is less able to travel to access health services than the elderly and frail. The challenge is to find a metric by which a simple determination may be made to confirm eligibility.

We feel strongly about the current ineligibility of certain rural for-profit hospitals to secure discounts via the Rural Healthcare Support Mechanism. In many rural communities, a for-profit hospital may be THE ONLY local provider of healthcare services. That for-profit status thereby prevents access to discounted telecommunications services that would allow for telehealth services to be delivered in a cost effective, affordable fashion. As an example, in two medically underserved counties in Southwest Virginia, the recent bankruptcy of two not-for-profit hospitals has resulted in the purchase of those facilities by a national for-profit corporation. In those counties, these hospitals remain the ONLY local provider of inpatient and emergency care. Today, these facilities are less able to support the cost of T1 connectivity than they were prior to acquisition by the corporate entity because of the incremental increase in telecommunications costs ($320/mo to $1000/mo) borne by the hospital once they no longer qualified for rural healthcare discounts.

With the tragic events of September 11, 2001, has come the recognition of the importance of rural considerations in our national state of emergency preparedness. Nuclear, chemical or bioterrorist events are as likely to impact our rural communities as our urban centers. These rural communities historically have been the least prepared to respond, by virtue of their geographic isolation from tertiary or quaternary medical expertise and our

nation's longstanding weak public health infrastructure. The benefits of affordable and enhanced connectivity to our rural hospitals cannot be overstated. The recent signing into law of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is further evidence of the intent of the Congress to strengthen our ability to interconnect telehealth networks in the service of rural preparedness.[4] Indeed, in the Telecommunications Act, the relationship between Universal service and public safety is clearly addressed. "The Joint Board in recommending, and the Commission in establishing, the definition of the services that are supported by Federal universal service support mechanisms shall consider the extent to which such telecommunications services--

(A) are essential to education, public health, or public safety….[and]

(D) are consistent with the public interest, convenience, and necessity."[5]

Thus, in service of rural preparedness for the public safety, we suggest that. facilitated by the Rural Healthcare Support mechanism, any hospital that serves as the sole hospital in a rural county should be permitted to secure discounted telecommunications services.

Moreover, the term "public" in the statute is not clear from the face of the statute. The term public has various meanings in other contexts. We suggest that the Congress did not have one firm meaning in mind when it drafted and signed into law the Telecommunications Act of 1996. Below we offer other arguments and reasonable precedents that could be used to support an expansion of the term public in relation to the Rural Healthcare Support Mechanism.

[4] Public Health Security and Bioterrorism Preparedness and Response Act of 2002, H3448.con.
[5] Section 254 7 (C) 1.

In addition, the FCC should choose to more broadly interpret the term public to include for-profit hospitals receiving public funds in the provision of a service or providing a public service (e.g., bioterrorism preparedness or response) that is not otherwise accessible through any other facility in the county. **Certain for-profit hospitals are thereby public in character by virtue of the beneficiaries they serve**.

As an example, in Virginia, of the ten highest ranking (% gross revenues from services provided to Medicare and Medicaid recipients) rural hospitals, four are for-profit entities. The referenced percent of gross revenues in service of Medicare and Medicaid patients in these hospitals ranges from 64-75%. Indeed, the top two, both for-profit entities, report % gross revenues of 75% in services provided to these beneficiaries. Those numbers do not include charity care.[6]

Thus, we suggest that in addition to the healthcare providers identified in the statute, Universal Service Fund discounts also be applied to:

- **Any for-profit hospital that serves patients when serving as the ONLY hospital in a rural county**
- **Any for-profit hospital providing services to Medicare and Medicaid patients at a level of more than 50% of their gross revenues accrued in services to these patients.**

Precedents for the Commission expanding the definition of "public" include the following examples from other federal agencies:

1) “Covered entities” for Section 340B of the Public Health Service Act, requires pharmaceutical companies participating in the Medicaid program to enter into a second agreement for discount outpatient drugs purchased by specific "government-supported" facilities called "covered entities" that serve the nation's

most vulnerable populations. The term "covered entities" includes certain federally qualified health centers, homeless clinics, etc. which are clearly not formally "public" entities.

2) "Public agency" for charter school disability requirements as used in section 300.22 of Title 20 , includes public charter schools that receive public funds but are not fully public entities.[7] When the rule was proposed, commenters requested, and the agency agreed, that the definition of public agency be amended to include charter schools that are the recipients of public funds in order to ensure that all public entities that are responsible for providing education to children with disabilities are covered. In that case, the agency used its discretion to go beyond the specific words of the statute.

3) "Public body" is defined in Title 24/Housing and Urban Development regulations as including private nonprofit organizations that are controlled 51% by public officials acting in their official capacities.[8] In that example, the regulatory agency interpreted the statute in a way that was not clear on the face of the statute

B. **Eligible services should include any form of broadband connectivity.**

1. Internet Access.[9]

We believe that discounts should be provided to support any form of Internet access provided to rural health care providers as long as the cost to provide such

[6] Data provided by Mr. Richard Walker, Virginia Health Information, Richmond, Va.
[7] 20 USC 1412(1)(1)(A), (a)(11).
[8] 24 CFR 572.5.
[9] NPRM at paragraph 11.

services in rural areas exceeds the same level of service in any urban area of the State. Nationwide, the delivery of telehealth services is moving toward an Internet Protocol (IP) environment. In that sense, whether the transport mechanism is T1, ISDN, Frame Relay, ATM, or DSL, the IP environment is still the same. It is the end-user devices (e.g., CODECs, teleradiology systems, PCs, etc) that translate digital information into useful telehealth services.

Discounts should be provided to underwrite access to Internet connectivity via any modality, to include "non-telecommunications service providers."[10]

In some communities, other providers of telecommunications technology such as the local cable operator or public utilities board have chosen to invest in infrastructure so as to provide broadband access to the Internet. Since many telemedicine networks have chosen to utilize broadband Internet connectivity for the delivery of interactive encounters between providers and patients, distance learning activities and teleradiology services, we believe that healthcare providers who choose to access those services should be eligible for discounts, if that connectivity provides the quality of service that supports its use for medical purposes. **That determination should be market driven, and not regulated by the FCC.**

2. Comparisons of services should be based on bandwidth rather than specific technology.[11]

We concur with the Commission that "some less expensive urban services are unavailable at any price in rural areas." Most rural health care providers do not have access

[10] Id. at paragraph 15.
[11] Id. at paragraph 23.

to the varieties of telecommunication services available to urban health care providers. Digital Subscriber Line (DSL) services are available in most urban areas, and are a cost effective means of providing connectivity for health care applications. These services are much less expensive than bandwidth-comparable services such as ISDN, Frame Relay or dedicated T-1/fractional T-1 connectivity. It does not matter to the healthcare provider whether a connection is classified as a telecommunications service or an information service, especially as telehealth networks migrate to IP protocols.

As stated above, comparisons of service should be based on bandwidth rather than specific technology. We have tested telehealth services over a variety of technologies, to include T1, SDSL, frame relay, ATM, and ISDN, and have found them equal in terms of clinical efficacy. We have found that the telecommunications technology deployed has not been the factor that drives acceptability of the clinician and patient, but rather the quality of service, the bandwidth of the connection and the cost of that connectivity.

We concur with the Commission and recognize that the price of satellite services does not differ between locations. We also concur with the Commission that the "widespread use of satellite-based services by rural health care providers that do have reasonably priced land-based alternatives, if fully funded by the rural health care mechanism, may prove costly for the universal support mechanism." [12]

Thus, in cases where satellite services are more expensive than locally available wireline services, it seems inappropriate to underwrite a connection via the more expensive satellite service with funds from the USAC. However, if no other terrestrial based service is available (insular areas) we believe it reasonable to underwrite the cost of access via satellite or other wireless connections.

We recommend the following:

- If no **other** terrestrial based service is available (as may be the case in remote and insular areas) we believe it reasonable to underwrite the cost of access via satellite or other wireless connections and discount those rates in a similar fashion to terrestrial based services in that state or closest state, if outside the continental United States.
- If the satellite rate costs no more than the highest published rate of the terrestrial service, then it is reasonable to underwrite the cost of access via satellite in rural areas that do have access to comparable bandwidth via terrestrial based services. This may foster innovative mobile applications which may allow health providers to travel to otherwise unwired towns, or to the scene of an accident.

We believe that modifications in these rules will support greater investment in broadband telecommunications infrastructure in our rural communities by existing providers of current and emerging technologies.

3. The rules should be modified to allow discounts that are benchmarked against rates provided in any city in the state, as per the statute.

The Telecommunications Act of 1996 did not mandate a rate comparison to the nearest city of 50,000. Moreover, the Commission has pointed out–that in many cases, a city which is larger than the nearest city of 50,000 will have available both a greater variety of telecommunications services and services at a lower rate attributable to competition. **We concur that the rules should be altered to allow comparisons based on telecommunications costs in any city in the state.**

[12] Id. at paragraph 31.

We estimated the cost to USAC of connecting one telemedicine site at T1 bandwidth in every rural county in Virginia, calculating discounts by comparing the costs based on comparable bandwidths secured via any other technology in any city in the Commonwealth. There are 73 rural counties (non-MSA) which could, based on rates for connectivity we have identified, be connected at a cost of $320/month, resulting in a distribution of $680 in discounts/site x 73 sites x 12 months = $595,680 in discounts for Virginia from USAC. If similar savings can be extrapolated to all 50 states, we project in an annual expense to the Rural Healthcare Corporation of $29,784,000, approximately double that expended in this past fiscal year by USAC, but still less than one tenth (7%) of the $400 million cap authorized by the Congress.

In addition, since patient referrals frequently bypass the nearest city of 50,000, we believe this selection of "nearest" urban area also artificially places undue constraints/restraints on referring physician trade practices within a state.

We therefore recommend that for purposes of calculation of discounts the FCC consider the following:

- The flexibility of comparison with ***any*** urban area in the state will allow comparison for purposes of discounts with communities with greater numbers of telecommunications providers and technologies.
- For purposes of simplicity, rural areas should be defined as a non-metropolitan statistical area (non-MSA). This definition conforms to CMS' final rule for eligibility for Medicare reimbursement, which allows reimbursement for telehealth consults in Health Professional Shortage Areas OR in non-MSAs. [13]

[13] Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000
Federal Register, Vol 66, Number 212, page 55282.

- **We recommend removal of any provision of distance calculation** which is cumbersome and does not take into actual patient travel mileage (versus the shortest distance between two points) which is in fact a more realistic measure of "distance" in terms of patient access to healthcare services. This would also greatly reduce the administrative burden of the Universal Services Administrative Corporation by allowing that agency to simply refer to federally standardized definitions of rurality.[14]

C. Other changes to the Rural Healthcare Support Mechanism.

1. Highest tariffed rates

The current mechanism fosters a disincentive for many telecommunication companies to invest in new technologies that may more affordable services to rural areas. The current regulation states that "common carriers must charge eligible rural health care providers a rate for each supported service that is no higher than the highest tariffed or publicly available commercial rate for similar service in the closest city in the state with a population of 50,000 or more people, taking distance charges into account." Allowing a telecommunications company the opportunity to charge their "highest tariffed" rate for services underwritten by USAC creates a disincentive to lower costs or to add new infrastructure or services which may be more affordable in rural areas.

Indeed, we are aware of one provider of connectivity that, upon learning of Rural Healthcare support availability for one of its subscribers, increased the charges to that subscriber to the highest tariffed rate (nearly double that previously negotiated) so as to secure additional revenues for its services, underwritten by the Rural Healthcare Support Mechanism.

[14] http://www.ruralhealth.hrsa.gov/ruralco.htm

2. Suggested policies to prevent fraud and abuse.

To avoid fraud and abuse of excessive charges by the provider of telecommunications or information services, **the FCC should mandate that all providers of connectivity confirm and post through USAC on a readily accessible web site, the commercially available advertised rates for services from which USAC funded discounts will be calculated.**

Such postings will also ensure that those rates will not be increased solely for purposes of recouping monies from the Universal Service Fund. Such an action will also facilitate the timely identification of rates for purposes of benchmarking by rural healthcare providers who otherwise have little means of securing this data other than contacting every telecommunications and information services provider in urban areas of the state. U. Va. and others have spent hundreds of hours attempting to identify benchmarked rates from the various providers of bandwidth, and have found there is little to no incentive for such providers to respond to our inquiries, when they are not to be the beneficiaries of the connectivity.

To avoid fraud and abuse of inappropriate securing of discounts by healthcare providers, prior to renewal of universal service discounts, **we recommend that USAC require annual documentation in which healthcare providers demonstrate utilization of the connectivity for clinical encounters/medical data transmission/health related education**. This documentation by the beneficiary of universal service discounts could be maintained by the healthcare provider and be subject to random audits by USAC.[15]

[15] NPRM at paragraph 21.

3. Calculation of discounted services could be simplified by eliminating the Standard Urban Distance (SUD), Maximum Allowable Distance (MAD) calculations and consider facilities eligible that are located in non-Metropolitan statistical areas.[16]

We recommend abandoning the Standard Urban Distance (SUD), Maximum Allowable Distance (MAD) calculations and simplify the administrative burden of USAC by permitting discounts to eligible healthcare facilities located in non-Metropolitan Statistical Areas.

4. The application process should be simplified.

The application process is both cumbersome and confusing to the unsophisticated healthcare provider. We have been advised by USAC that more than 30% of healthcare facilities fail to renew requests for discounts because of administrative complexity.[17] **We recommend that USAC consider multiyear approvals in selected instances.**

We request that USAC develop a process by which payment of the telecommunications discounts accrue directly to the provider of connectivity so that the healthcare provider (in many cases, a financially limited facility) is freed from the burden of prepaying the total cost of the telecommunications service and then seeking reimbursement for the discounts. Alternatively, the recipient could be allowed to assign payment to the telecommunications provider.

The complete process should be simplified to include a single application in which the healthcare provider provides USAC with the following documentation:

[16] Id. paragraphs 23-31.
[17] Personal communication in telephone call with Mr. Bill England of USAC.

a) Status of healthcare provider (hospital, community health center, for-profit status, sole hospital in rural county) with Tax ID number;
b) In cases of for-profit hospitals, documentation of Medicaid and Medicare % gross revenues (greater than 50% as the bar above which discounts may be applied);
c) Location in a non-MSA;
d) Type of telecommunications service requested;
e) Benchmarked rate based on postings of available rates in any city in the state; and
f) Local telecommunications provider selected to provide service and discounted rate based on postings.

5. Pro-rata reductions if annual cap exceeded.[18]

We agree with the need to reduce distribution if the cap is exceeded. **We recommend an elimination of discounts provided to those rural communities in which enhanced competition has developed, in the form of more than two providers of broadband services available in that community.**

6. Partnerships with clinics in schools and libraries.

We recommend that a school based clinic be allowed access to the discount rates afforded through the schools and libraries program as those discounts have been generally been associated with greater discounts than those associated with the rural healthcare support mechanism. As an example, using the same telecommunications provider, a rural school in Buchanan County, Virginia , after receiving Schools and Libraries discounts, pays $184/month for T1 connectivity. With Rural Healthcare discounts the cost of that connection would nearly double. Justification of grouping of school based clinics with discounts offered by the Schools and Libraries Program includes the use of these clinics for health related educational programs for children.

[18] NPRM paragraphs 47-48.

D. Conclusion.

We commend the FCC for considering a modification of the rules of the Rural Healthcare support mechanism. With the changes outlined above, the vision of the Congress to enhance connectivity in the service of improving access to healthcare and health related education programs in rural America can become a reality.

Karen S. Rheuban, MD
Medical Director

Eugene Sullivan, MS
Director

Office of Telemedicine
University of Virginia Health System